MATERNITY CARE PROGRAM
EXEMPTION REQUEST

MEDICAID RECIPIENT INFORMATION

NAME________________________________ DOB___________________ EDC _______________

ADDRESS ____ City____________________

COUNTY _________________________ ZIP _____________________ DISTRICT ______

MEDICAID # _______________________ PRIMARY CONTRACTOR __________________
DATE STARTED PRENATAL CARE: _________________
Signature of Program Director ______________________________ Date _________________

REASON FOR EXEMPTION REQUEST

1. MEDICAL NECESSITY ______
Diagnosis/Condition ____

I am certifying that this recipient requires continuous prenatal care and delivery services from a facility that is certified to provide high risk delivery services.

____
Signature DHCP _________ HIGH RISK PROVIDER ____________

2. MEDICAID ELIGILBILTY GRANTED LATE IN PREGNANCY _____
Date of Medicaid application _________ (date must be verified)
Has the non-subcontracted provider agreed to continue pregnancy care and delivery for the recipient? _____

3. Other ___ Please attach documentation

4. HMO INSURANCE
Name of Insurance Company ____
Policy #_______________________________ Effective Date ________________

Note: Please include the following attachments:

- **Statement from high risk facility**
- **Medical record**
- **MD statement**

FOR MEDICAID USE ONLY
Date Returned _________________ Approved__________ Denied_________________
Reason____
____
____
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